Pational Medicare
TRAINING PROGRAM
CENTERS FOR MEDICARE & MEDICARD SERVICES

Medicaid & the Children's Health Insurance Program (CHIP) Module 12



...helping people with Medicare make informed health care decisions



Centers for Medicare & Medicaid Services National Train-the-Trainer Workshops Instructor Information Sheet

Module 12: Medicaid & the Children's Health Insurance Program (CHIP)

Module Description

Medicaid & the Children's Health Insurance Program (CHIP) explains programs for people with limited income and resources.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included.

The following sections are included in this module:

Slides	Topics
2	Session Objectives
3	Lessons
4-36	Medicaid Overview
37-42	Medicare Savings Programs
43-50	CHIP
51-52	Coverage in U.S. Territories
53-54	Information Sources

Objectives

- Define Medicaid
- Identify Medicare Savings Programs (MSP)
- Describe the Children's Health Insurance Program (CHIP)
- Understand How to Obtain Coverage in U.S. Territories

Target Audience

This module is designed for presentation to trainers and other information givers. It is suitable for presentation to groups of beneficiaries.

Handouts

Slides 6, 39-40, and 47 are provided as full page handouts in the Appendix of this workbook. Also included is a copy of the letter from CMS to State Health Official/State Medicaid Directors Re: New Option for Coverage of Individuals under Medicaid, dated April 9, 2010. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

Time Considerations

The module consists of 54 PowerPoint slides with corresponding speaker's notes. It can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers.

References

For more information on Medicaid visit www.cms.gov/home/medicaid.asp or contact your State Medicaid Office For more information on the Children's Health Insurance Program (CHIP) visit www.cms.gov/home/chip.asp For more information on the Social Security Act visit www.ssa.gov/OP_Home/ssact/comp-ssa.htm For more information on Health Care Reform, visit www.healthcare.gov



Module 12 explains Medicaid & the Children's Health Insurance Program (CHIP).

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).



This symbol is used in this presentation to highlight changes based on new legislation.

The information in this module was correct as of June 2010. To check for updates on health care reform, visit www.healthreform.gov. To check for an updated version of this training module, visit www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp on the Web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Session Objectives

This session will ensure you can

- Define Medicaid
- Identify Medicare Savings Programs (MSP)
- Describe the Children's Health Insurance Program (CHIP)
- Understand how to obtain coverage in U.S. Territories

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Medicaid & the Children's Health Insurance Program

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■ This session will ensure you can

- Define Medicaid
- Identify Medicare Savings Programs (MSP)
- Describe the Children's Health Insurance Program (CHIP)
- Understand how to obtain coverage in U.S. Territories

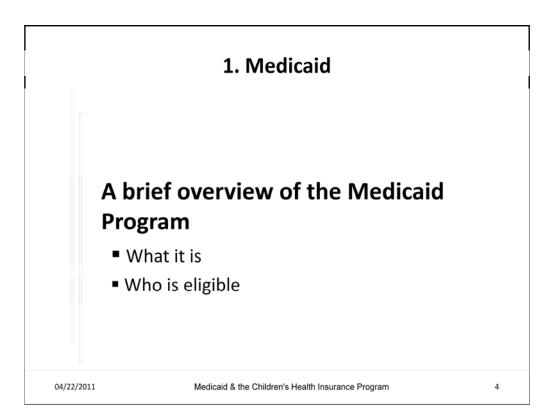
Lessons

- 1. Medicaid
- 2. Medicare Savings Programs
- 3. Children's Health Insurance Program (CHIP)
- 4. Coverage in U.S. Territories

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Medicaid & the Children's Health Insurance Program

- This module includes lessons on
 - 1. Medicaid
 - 2. Medicare Savings Programs
 - 3. Children's Health Insurance Program (CHIP)
 - 4. Coverage in U.S. Territories



- This section includes an overview of the Medicaid program.
 - What it is
 - Who is eligible

Medicaid Overview

- Title XIX of the Social Security Act
- Established by Congress in 1965
- Medical assistance for people with limited income and resources
- Covers 58M adults/children
- Augments Medicare for 7M aged/disabled

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Medicaid & the Children's Health Insurance Program

- The Medicaid Program, Title XIX (19) of the Social Security Act, is a Federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.
- The program became law in 1965 as a cooperative venture jointly funded by the Federal and state governments (including the District of Columbia and the Territories), to assist states in furnishing medical assistance to eligible needy persons.
- Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

How are Medicare and Medicaid different?			
Medicare	Medicaid		
National program that is consistent across the country	Statewide programs that vary among states		
Administered by the Federal government	Administered by state governments within Federal rules (Federal/state partnership)		
Eligibility based on age, disability, or End–Stage Renal Disease (ESRD)	Eligibility based on need; financial and non-financial requirements		
Nation's primary payer of inpatient hospital services to the elderly and people with ESRD	Nation's primary public payer of acute health, mental health, and long-term care services		
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Medicare and Medicaid are different in the following ways

- While Medicare is a national program that is consistent across the country, Medicaid consists of statewide programs that vary among states.
- While Medicare is administered by the Federal government, Medicaid is administered by state governments within Federal rules (Federal/state partnership).
- While Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD), Medicaid eligibility is based on income and resources.
- While Medicare is the nation's primary payer of inpatient hospital services to the elderly and people with ESRD, Medicaid is the nation's primary public payer of acute health, mental health, and long-term care services.

NOTE: This chart is provided as a handout in the corresponding workbook (see Appendix A).

Medicaid Administration

- Federal/state partnership
 - Jointly financed entitlement program
 - Federally established national guidelines
 - States receive Federal matching funds
 - Known as Federal Medical Assistance Percentage (FMAP)
 - Used to calculate amount of Federal share of State expenditures
 - Varies from state to state
 - o Based on state per capita income

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Medicaid is a joint Federal/state partnership program. States receive Federal matching funds for covered services. The Federal matching rate, also known as the Federal Medical Assistance Percentage (FMAP), is used to calculate the amount of Federal share of State expenditures for services. The FMAP varies from state to state based on state per capita income.

Medicaid Administration

- Within broad Federal guidelines, each state
 - Develops its own programs
 - Develops and operates its State plan
 - Establishes its own eligibility standards
 - Determines the type, amount, duration & scope of services
 - Sets the rate of payment for services
 - Administers its own program
- States may change eligibility, services, reimbursement

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Medicaid & the Children's Health Insurance Program

- Within broad Federal guidelines, each state
 - Develops its own programs
 - Develops and operates a State Plan outlining the nature and scope of services
 - The State Plan is a contract between CMS and the state, and any amendments must be approved by CMS
 - Establishes its own eligibility standards. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity
 - A person who is eligible for Medicaid in one state may not be eligible in another state.
 - Determines the type, amount, duration and scope of services covered. Also, the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state
 - Sets the rate of payment for services
 - Administers its own program
- State legislatures may change Medicaid eligibility, services, and reimbursement during the year.

The Single State Medicaid Agency

- Administers the state's Medicaid plan
 - May delegate some administrative functions
- Local office names may vary
 - Social Services
 - Public Assistance
 - Human Services

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- The Single State Medicaid Agency is responsible for administration of the Medicaid state plan. The Single State Agency is not required to administer the entire Medicaid program; it may delegate some administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.
- For more information about eligibility requirements in your state, you may contact the State Medicaid Director in your state. Local office names may vary. To apply for Medicaid, you'll need to contact your local Medicaid Assistance office. These office are also called Social Services, Public Assistance, and Human Services depending on where you live.

Mandatory Medicaid State Plan Benefits

- Physician services
- Laboratory & X-ray
- Inpatient hospital
- Outpatient hospital
- Early Periodic Screening & Diagnostic Testing
- Family planning
- Rural and Federally-qualified health centers
- Nurse-midwife services
- Nursing facility services for adults
- Home health
- Cost sharing for Dual Eligibles

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- Some Medicaid State Plan benefits are mandatory (must be covered by the state); some are optional (state may choose to cover).
- MANDATORY
 - Physician services
 - Laboratory & X-ray
 - Inpatient hospital
 - Outpatient hospital
 - EPSDT (Early Periodic Screening & Diagnostic Testing)
 - Family planning
 - Rural and Federally-qualified health centers
 - Nurse-midwife services
 - Nursing Facility services for adults
 - Home health
 - Cost sharing for Dual Eligibles

Optional Medicaid State Plan Benefits

- Dental services
- Therapies PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- Intermediate Care Facility for the Mentally Retarded
- Psychiatric Residential Treatment Facility for <21
- Rehabilitative services
- Special services in waivers and demonstrations

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OPTIONAL

- Dental services
- Therapies Physical Therapy/Occupational Therapy/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- ICF/MR Intermediate Care Facility for the Mentally Retarded
- Psychiatric Residential Treatment Facility for those under age 21
- Rehabilitative services
- Special services in waivers and demonstrations

Medicaid Eligibility

- Not all people with low income/resources are eligible
- Must be a member of a "group"
 - Non-Financial requirements
 - Financial requirements

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- Not all people with low income/resources are eligible
- To be eligible for Medicaid you must be a member of a "group"
 - Non-Financial requirements
 - Financial requirements

NOTE: The Affordable Care Act includes a new "group" that will be covered later in this presentation.

Medicaid Eligibility Groups

- Eligibility based on cash assistance program
 - Supplemental Security Income (SSI)
 - Aged
 - Blind
 - Disabled
 - Aid to Families with Dependent Children (AFDC)
 - Pregnant women with income under 133% FPL
 - Children ages 6-18/income below 100% FPL

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- Medicaid eligibility is based on the most closely associated cash assistance program.
 - SSI: The SSI (Supplemental Security Income) program provides cash benefits to aged, blind or disabled people. It is a means-tested program that has specific rules, requirements, and processes for determining eligibility. Because it is the most closely related cash assistance program for this population, SSI program rules are used to establish Medicaid eligibility for SSI-related groups (persons who are aged, blind or disabled).
 - Aid to Families with Dependent Children (AFDC): The AFDC program was replaced with the Temporary Assistance for Needy Families (TANF) program in 1997, but worked almost the same way as the SSI program, but for children, families with dependent children, and pregnant women. Because AFDC was the most closely related cash assistance program for this population, AFDC rules are used to establish Medicaid eligibility for AFDC-related groups (children, families with children, and pregnant women).
- Here are a few examples of groups:
 - People receiving SSI benefits
 - Pregnant women with income under 133% of the Federal Poverty Level (FPL)
 - Children ages 6-18 with income below 100% FPL

Dual Eligible Beneficiary

- Dual eligible means eligible for Medicare and Medicaid
 - You may receive payment by Medicaid
 - Part A and/or Part B premiums
 - Other Medicare cost-sharing
 - Coverage of certain services not covered under Medicare

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Medicaid & the Children's Health Insurance Program

- Dual eligible means eligible for Medicare and Medicaid
- Dually eligible people may receive:
 - Payment by Medicaid of Part A and/or Part B premiums, and sometimes other Medicare costsharing
 - Medicaid coverage of certain services not covered under Medicare

Non-Financial Requirements

- State resident
- Citizen or qualified alien
- Must have Social Security number
- Assignment of rights to medical support and payment

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- Non-financial requirements include
 - The state you reside in
 - Whether you are a citizen or qualified alien
 - You must have a Social Security number
 - You must assign rights to medical support and payment

Non-Financial Categorical Requirements

- Majority of all Medicaid eligibility groups
 - Pregnant
 - Under age 21 (children)
 - Aged, blind, or disabled
 - A parent or caretaker of a child
- Must also satisfy financial and non-financial requirements

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- Majority of all Medicaid eligibility groups consist of the following individuals
 - Pregnant women
 - People under age 21 (children)
 - People who are aged, blind, or disabled
 - A parent or caretaker of a child
- To qualify you must also satisfy financial and non-financial requirements.

Financial Requirements

- Divided into two broad areas
 - Income requirements
 - Resource requirements
- Rules for counting income and resources vary
 - From state to state
 - From "group" to "group"
- Special rules
 - Those who live in nursing homes
 - Disabled children living at home

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Medicaid & the Children's Health Insurance Program

- The financial requirements are divided into two broad areas
 - Income requirements
 - Resource requirements
- The rules for counting your income and resources vary from state to state and from "group" to "group".
- There are special rules for those who live in nursing homes and for disabled children living at home.

What is Income?

- Anything that could purchase food or shelter
- Two types
 - Earned income
 - · Wages and salary
 - · Compensation for work
 - Unearned income
 - · Social Security Disability Insurance
 - · Retirement benefits
 - · Interest and dividends

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Medicaid & the Children's Health Insurance Program

- Income is anything that you could use to purchase food or shelter.
- There are two types of income
 - Earned income, such as wages, salary, or any compensation for work.
 - Unearned income, such as of Social Security Disability Insurance, retirement benefits, and interest and dividends

What are Resources?

- Cash
- Anything owned that can be converted to cash
- Liquid resources
 - Savings accounts
 - Stocks and bonds
 - Other assets that could be cashed
- Real estate (other than your home)

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Medicaid & the Children's Health Insurance Program

- The following are considered resources
 - Cash
 - Anything you own that can be converted to cash
 - Liquid resources like savings accounts, stocks, bonds, or anything that could be cashed
 - Real estate you own, other than your home

Mandatory and Optional Groups

- Mandatory Groups
 - Required by Federal law
 - States must cover
- Optional Groups
 - Not required by Federal law
 - States may or may not choose to cover

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Medicaid & the Children's Health Insurance Program

- There are mandatory groups and optional groups.
 - Mandatory groups are those that Federal law requires states to cover.
 - Optional groups are those that Federal law does not require to be covered by states, but that states may choose to cover.

Mandatory Eligibility Groups

- Limited income families with children
- Supplemental Security Income (SSI) recipients
- Infants born to Medicaid-eligible women
 - Eligibility must continue throughout first year
 - · Infant remains in the mother's household AND
 - Mother remains eligible OR
 - Mother would be eligible if she were still pregnant

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- The following specifies the mandatory Medicaid ("categorically needy") eligibility groups for which Federal matching funds are provided.
 - Limited income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the state's Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996.
 - Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria-aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the state's approved Medicaid plan as of January 1, 1972).
 - Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue
 throughout the first year of life so long as the infant remains in the mother's household
 and she remains eligible, or would be eligible if she was still pregnant.

Mandatory Eligibility Groups

- Income levels apply
 - Low-income pregnant women
 - Low-income children under age 6
 - Low-income children ages 6-19
 - Recipients of adoption assistance and foster care
 - Certain low-income Medicare beneficiaries

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The groups Federally required to be covered by states include the following

- Pregnant women and children under age 6 whose family income is at or below 133% of the Federal poverty level. (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133% percent, if as of certain dates the State had established a higher percentage for covering those groups.)
 - Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.
- Children age 6 until age 19 in families with incomes at or below the Federal poverty level
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security
 Act
- Certain Medicare low-income beneficiaries.

Optional Eligibility Groups

- State Supplementary Income Payment recipients
- Individuals in institutions with relatively high income
- Working Disabled
- Medically Needy (income above the eligibility level)
 - May qualify immediately
 - Must "spend down" to qualify

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- States also have the option of providing Medicaid coverage for other optional groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.
- The broadest optional groups for which states will receive Federal matching funds for coverage under the Medicaid program include the following
 - Recipients of state supplementary income payments
 - Individuals in institutions with relatively high income
 - The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) created two new eligibility groups for working disabled individuals. Both are optional for the states, and both went into effect October 1, 2000.
- The states have the option of extending Medicaid coverage to medically needy individuals who are not otherwise eligible for Medicaid because of excess income. The individual's incurred medical costs are deducted from income over an accounting period of one to six months. If the net result is below the state-established "medically needy" income level, the individual will qualify for Medicaid coverage for the remainder of the accounting period. This can provide access to Medicaid coverage for individuals with recurring drug and medical expenses that are high in relation to their monthly income.
- The medically-needy group is an optional group consisting of individuals who would be eligible for Medicaid, except that their income is above a level that would otherwise make them eligible for Medicaid.
 - Individuals must "spend down" to qualify

Medically Needy

- If a state has a medically needy program, it must cover
 - Children under age 19 who are full-time students
 - Pregnant women who are medically needy
 - Prenatal and delivery care for pregnant women
 - Certain newborns for 1 year
 - Protected blind persons
 - Ambulatory care for children

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Medicaid & the Children's Health Insurance Program

- If a state has a medically needy program it must cover the following
 - Children under age 19 who are full-time students
 - Pregnant women who are medically needy
 - Prenatal and delivery care for pregnant women
 - Certain newborns for 1 year
 - Protected blind persons (those eligible as medically needy under Medicaid in December 1973
 on the basis of the blindness or disability criteria and meet the current requirements for
 eligibility as medically needy under Medicaid except for blindness or disability criteria)
 - Ambulatory care for children
- The following states have medically needy programs

 Arkansas, Hawaii, Maine, Nebraska, Pennsylvania, Vermont, California, Illinois, Maryland, New Hampshire, Puerto Rico, Virginia, Connecticut, Iowa, Massachusetts, New Jersey, Rhode Island, Washington, Dist. of Columbia, Kansas, Michigan, New York, Tennessee, West Virginia, Florida, Kentucky, Minnesota, North Carolina, Texas*, Wisconsin, Georgia, Louisiana, Montana, North Dakota, and Utah
- *The medically needy program in Texas covers only the "mandatory" medically needy groups. It does not cover the aged, blind and disabled.

Pregnant Woman

- Apply for Medicaid if you think you are pregnant
 - Covered whether married or single
 - Both you and your child will be covered

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Medicaid & the Children's Health Insurance Program

- Apply for Medicaid if you think you are pregnant. You may be eligible if you are married or single.
- If you are covered by Medicaid when your child is born, both you and your child will be covered.

Children

- Your child may be eligible for coverage
 - U.S. citizen
 - Lawfully admitted immigrant
- Eligibility based on the child's status, not the parent's
- If someone else's child lives with you
 - Child may be eligible even if you are not
 - Your income/resources will not count for the child

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- Your child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if you are not (however, there is a 5-year limit that applies to lawful permanent residents).
- Eligibility for children is based on the child's status, not the parent's status. Also, if you are caring for someone else's child who lives with you, the child may be eligible even if you are not because your income and resources will not count for the child.
- Apply for Medicaid if you are the parent or guardian of a child who is 18 years old or younger and your family's income is limited, or if your child is sick enough to need nursing home care, but could stay home with good quality care at home.
 - If you are a teenager living on your own, the state may allow you to apply for Medicaid on your own behalf or any adult may apply for you.
 - Many states also cover children up to age 21.

Aged, Blind, Disabled

- Apply if you are aged, blind, or disabled and
 - Have limited income and resources
 - Are terminally ill and want to get hospice services
 - Live in a nursing home with limited income and resources
 - Need nursing home care (may get community care services)
 - Eligible for Medicare with limited income and resources

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Medicaid & the Children's Health Insurance Program

- Apply if you are aged (65 years old or older), blind, or disabled and one of the following
 - You have limited income and resources
 - You are terminally ill and want to get hospice services
 - You live in a nursing home and have limited income and resources
 - You need nursing home care, but can stay at home with special community care services
 - You are eligible for Medicare and have limited income and resources

New Option for Medicaid Coverage

- New eligibility group VIII
 - Must be covered as of January 2014
- New in 2011
- States have option to begin covering April 1, 2010
- New group fills the gaps in existing Medicaid eligibility
- Includes very-low income individuals not otherwise eligible
 - Income can't exceed 133% FPL
 - No asset test

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The Affordable Care Act; P. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010; P. L. 111-152 establishes a new eligibility group that all States participating in Medicaid must cover as of January 2014.



Section 2001(a)(4) adds a new subsection (k)(2) of section 1902 of the Social Security Act (the Act), which permits States to cover this group of individuals at State option, or to phase-in coverage of the group based on income, beginning April 1, 2010.

- New eligibility group VIII
 - Must be covered as of January 2014
 - States have the option to begin covering this group starting April 1, 2010
 - New group fills the gaps in existing Medicaid eligibility
 - Includes very-low income individuals not otherwise eligible. Their income can't exceed 133% of the FPL and there is no asset test.

New Option for Medicaid Coverage

Group VIII includes those who are not

New in 2011

- Age 65 or older
- Pregnant
- Entitled to or enrolled in benefits under Medicare Part A
- Enrolled under Medicare Part B
- In any other mandatory group

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•Group VIII fills in the gaps in existing Medicaid eligibility. It makes eligible very-low income individuals who aren't otherwise eligible under mandatory eligibility categories. This new eligibility group includes those who are not age 65 or older; pregnant; entitled to or enrolled in benefits under Medicare Part A; enrolled under Medicare Part B; or described in any of the other mandatory groups (I-VII) in the statute, such as certain parents, children, or people eligible based on their receipt of benefits under the Supplemental Security Income (SSI) program.



Under section 1902(k)(2) of the Act, until 2014, States may elect to "phase-in" coverage for this new eligibility group at any time, effective April 1, 2010. States do not have to wait until January 2014 to cover adults they've previously had no authority to cover under a State plan, including adults under age 65 who are neither disabled, pregnant, nor living with dependent children and who don't have other special circumstances. Depending on the categories and income levels a State now covers and the income level a State decides to set for Group VIII under the 1902(k)(2) option, the new group also could include other low-income adults, including parents and people with disabilities who don't receive SSI.

■ For example, if a State has not otherwise expanded coverage for parents or people with disabilities up to an income level of 100% of the Federal poverty level (FPL), and it adopts the 1902(k)(2) option up to that income level, the new group would include adults not eligible under other categories, including some parents and people with disabilities. By contrast, if a State already covers parents and people with disabilities with incomes up to 100 % of the FPL and implements the 1902(k)(2) option up to that income level, the individuals eligible under the new option generally would be limited to the childless adults ineligible under the other categories.

Note: The letter to State Health Officials and Medicaid Directors on this topic is provided in the corresponding workbook (see Appendix B).

Medicaid Health Homes

- Creates a new Medicaid state option
- Enrollees can designate provider as health home

New in 2011

- States provided with 90% federal matching payments
- Started January 1, 2011

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Medicaid Health Homes

- Creates a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the option with 90% federal matching payments for two years for health home-related services.
- Starts January 1, 2011.
- Health Home services are defined as "comprehensive and timely high quality services,"
- Includes the following services to be provided by designated health home providers or health teams:
 - Comprehensive care management;
 - Care coordination and health promotion;
 - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
 - Individual and family support, which includes authorized representatives;
 - Referral to community and social support services, if relevant; and
 - The use of health information technology to link services, as feasible and appropriate.
- Modeled after the Patient-Centered Medical Home (PCMH)
 - Care provided by physician-led practices
 - Seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages, acute, chronic, preventive, and end of life, and a long-term therapeutic relationship.
 - The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services.
 - o The individual decides who is on the team and the primary care physician makes sure team members work together to meet the individual's needs in an integrated fashion.



See Section 2703 of the Affordable Care Act.

Chronic Disease Prevention

New in 2011

- Provides grants to states to provide incentives to Medicaid beneficiaries
 - Who participate in prevention programs
 - Demonstrate changes in health risk and outcomes
- Application by a State for a grant must address specific prevention goals
- CMS will accept only one application per State

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Section 4108 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (The Affordable Care Act) authorizes grants to States to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives or programs are to be "comprehensive, evidence-based, widely available, and easily accessible." The programs must use relevant evidence-based research and resources, including: the Guide to Community Preventive Services; the Guide to Clinical Preventive Services; and the National Registry of Evidence-Based Programs.

- An application by a State for a grant under the program must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition. The purpose of the program is to test and evaluate the effect of the initiative on the use of health care services by Medicaid beneficiaries participating in the program; the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and the administrative costs incurred by State agencies that are responsible for administration of the program.
- The Office of the Governor or the State Medicaid Agency may apply for funding under this grant opportunity. CMS will accept only one application per State; therefore we encourage State offices and agencies to work collaboratively to develop one application packet. State Notices of Intent are due to CMS by April 4, 2011. Complete Grant Applications are due to CMS by May 2, 2011. Successful applicants will receive a Notice of Grant Award signed and dated by the CMS Grants Management Officer via U.S. Postal Service by August 1, 2011. Grantees must apply annually for incremental funding.
- Participating States must commit to operating their program for at least 3 years, conducting a State-level evaluation, and fulfilling reporting requirements specified by the legislation and CMS, including information technology system modification necessary to support the evaluation and reporting requirements. Approved administrative and program expenditures will be reimbursed through grant funds from the \$100 million dollars appropriated for this program and evaluation. There is no State cost sharing requirement in this program.
- For more information about this initiative please visit:
- http://www.cms.gov/MIPCD/Downloads/HHS_ACA_S4108_Solicitation.pdf

Medicaid Hospital-Acquired Infections

- Prohibits federal payments to states for Medicaid services related to certain hospitalacquired infections
- Starts July 1, 2011

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- Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections
- Starts July 1, 2011

Long-Term Care Services

Provides for enhanced federal matching payments for community based long-term care services

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New

- Creates the State balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services
- Establishes the Community First Choice Option in Medicaid to provide community-based long-term care services
 - Goal is to provide community-based attendant support services to certain people with disabilities.

Limited Income Newly Eligible Transition Program

- Called LI-NET
- Combines auto-enrollment and Point-of-Sale Facilitated Enrollment
- For full duals and SSI-only beneficiaries
- Provides Part D coverage for all uncovered
 - Full duals and SSI-only beneficiaries retroactively
 - LIS eligible beneficiaries on a current basis

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Medicaid & the Children's Health Insurance Program

- The Limited Income Newly Eligible Transition Program is called LI NET. It is a new CMS program that combines, and improves upon, CMS' existing Auto-Enrollment process for Full Duals and SSI-only beneficiaries and Point-of-Sale Facilitated Enrollment (POS FE) process for all Low-Income Subsidy (LIS) eligible beneficiaries.
- The LI NET Program will provide Part D prescription drug coverage for
 - All uncovered Full Duals and SSI-only beneficiaries on a retroactive basis; and
 - All uncovered LIS eligible beneficiaries on a current basis.
- The LI NET Program will be operated by Humana, Inc. on behalf of CMS.

Access to LI-NET

- Three ways to access the LI-NET program
 - 1. Auto-Enrollment by CMS
 - 2. Point of Service (POS) Use
 - 3. Submitting a receipt (Rx already paid out-of-pocket)
 - During eligible periods

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Medicaid & the Children's Health Insurance Program

- \blacksquare There are three ways to access the LI-NET program
 - 1.Auto-Enrollment by CMS
 - CMS has performed auto-enrollment of full duals on a daily to monthly basis since the start of the Part D Program. CMS will continue to generate auto-enrollments, but into the LI NET Program only.
 - 2.Point of Service (POS) Use.
 - Beneficiary presents at the pharmacy with an immediate prescription drug need
 - Coverage between 30 days and 36 months prior to date of submission
 - Exception to the 36-month rule: beyond 36 months for those who had a recent Medicaid determination (within 90 days) with an effective date greater than 36 months in the past, as far back as 1/1/06
 - Only Full Duals and SSI-Only beneficiaries are eligible for retroactive coverage
 - 3. Submitting a receipt For prescriptions already paid for out-of-pocket during eligible periods

LI-NET Coverage and Enrollment

- Coverage
 - Full Dual/SSI-only up to 36 months
 - Partial Dual/LIS Applicants up to 30 days
 - Unconfirmed up to 7 days
- Enrolled in LI NET for temporary coverage
 - In Standard PDP for future coverage
- Open Formulary, No Prior Authorization, No Pharmacy Restrictions
- Standard PDP Rights for Enrollees, Eligibility Reviews for Non-Enrollees

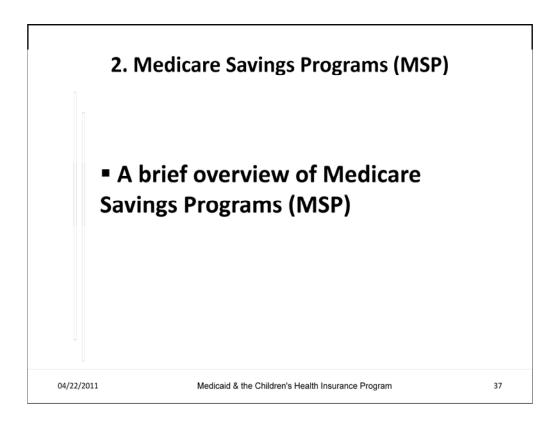
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Medicaid & the Children's Health Insurance Program

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Coverage

- Full Dual/SSI-only up to 36 months
- Partial Dual/LIS Applicants up to 30 days
- Unconfirmed up to 7 days
 - Unconfirmed beneficiaries are those who show evidence of Medicaid or LIS eligibility to the pharmacy at POS, but for whom there is no evidence of Medicaid or LIS eligibility in CMS' systems
 - Coverage up to 7 days prior to the date of submission of the claim to LI NET
 - Unconfirmed beneficiaries will undergo a back-end eligibility verification through state eligibility verification systems (EVS).
 - If beneficiary is determined to be ineligible, he/she is responsible for cost of claim(s) unless he/she can provide proof of eligibility to the LI NET Program using best available evidence (BAE)
- Full Duals and SSI-only beneficiaries will have an enrollment effective date of the first day of full dual status or the last uncovered month, whichever is later
- Partial Duals and LIS Applicants will not be automatically enrolled into the LI NET Program
- Enrolled in LI NET for temporary coverage
 - In Standard PDP for future coverage
- Benefits
 - Open Formulary, No Prior Authorization, No Pharmacy Restrictions
 - Standard PDP Rights for Enrollees, Eligibility Reviews for Non-Enrollees



• *Medicare Savings Programs (MSP)* explains programs that help pay Medicare costs for people with limited income and resources.

Medicare Savings Programs

- Help for people with limited income and resources
- Frequently have higher income/resource guidelines
- Pay Medicare premiums
- May pay Medicare deductibles and coinsurance
- Income amounts updated annually with FPL
- Some states offer their own programs

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Medicaid & the Children's Health Insurance Program

- States have other programs that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance for people with limited income and resources. These programs frequently have higher income and resource guidelines than Medicaid. These programs are collectively called Medicare Savings Programs.
- Eligibility for these programs is determined by income and resource levels. The income amounts are updated annually with the Federal poverty level.
- Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs.
- You can contact your local Medicaid office or the State Health Insurance Assistance Program (SHIP) in your state to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	 Eligible for Medicare Part A Income not exceeding 100% FPL Resources not exceeding the full LIS subsidy resource level For 2010: \$6,600 individual/\$9,910 married couple living together with no other dependents Effective the first of the month after QMB eligibility is determined Eligibility cannot be retroactive 	Part A and Part B premiums, deductibles, co-insurance, and copays
Specified Low-income Medicare Beneficiary (SLMB)	 Eligible for Medicare Part A Income at least 100%, but not exceeding 120% of FPL Resources not exceeding the full LIS subsidy resource level For 2010 \$6,600 individual/\$9,910 married couple living together with no other dependents Eligibility begins immediately and can be retroactive up to three months 	Part B premium
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- The Qualified Medicare Beneficiary (QMB) program was established by the Medicare Catastrophic Coverage Act of 1988. To qualify for QMB you must be eligible for Medicare Part A, and have an income not exceeding 100% of the Federal Poverty Level (FPL). This will be effective the first month following the month QMB eligibility is approved. Eligibility cannot be retroactive. If you qualify for QMB, you get help paying your Part A and Part B premiums, deductibles, co-insurance, and copays.
- The Specified Low-income Medicare Beneficiary (SLMB) program was established by OBRA law of 1990 and became effective January 1, 1993. To qualify for SLMB, you must be eligible for Medicare Part A and have an income that is at least 100%, but does not exceed 120% of the FPL. If you qualify for SLMB, you get help paying for your Part B premium.

NOTE: Effective January 1, 2010, the resource limits for the QMB, SLMB and QI programs are \$6,600 for a single person and \$9,910 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year. States must use the new resource limits when determining eligibility for these programs.

NOTE: This chart and the chart on the following page are provided as a handout in the corresponding workbook (see Appendix C).

Medicare Savings Program	Eligibility	Helps Pay Your
Qualified Individual (QI)	 Eligible for Medicare Part A Income at least 120% but does not exceed 135% FPL Resources not exceeding the full LIS subsidy resource level For 2010 \$6,600 for an individual/\$9,910 married couple living together with no other dependents Eligibility begins immediately and can be retroactive up to three months 	Part B premium
Qualified Disabled and Working Individual (QDWI)	 Entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA) Income not higher than 200% FPL Resources not exceeding twice maximum for SSI For 2010: \$4,000 for an individual/\$6,000 married couple living together with no other dependents Cannot be otherwise eligible for Medicaid 	Part A premium
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- The Qualified Individual (QI) program was established by the BBA of 1997. It is fully Federal funded. Congress only appropriated a limited amount of funds to each state. To qualify for QI, you must be eligible for Medicare Part A, and have an income not exceeding 135% of the Federal Poverty Level (FPL). If you qualify for QI, and there are still funds available in your state, you get help paying your Part B premium.
- The Qualified Disabled and Working Individual (QDWI) program was established by the OBRA law of 1989. To qualify for QDWI, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA), and have an income not higher than 200% of the FPL, and you cannot be otherwise eligible for Medicaid. If you qualify you get help paying your Part A premium. States can charge premiums if income is between 150% and 200% FPL. Resources not exceeding twice maximum for SSI (in 2010 \$4,000 for an individual and \$6,000 for married couple).

NOTE: This chart is provided as a handout in the corresponding workbook (see Appendix C).

Medicaid Waivers

- Waivers allow states alternative delivery of care
 - May not comply with certain Federal statutes
- Types of waivers
 - Section 1915(b) freedom of choice waivers
 - Section 1915(c) home and community-based waiver
 - Section 1115 research and demonstration waiver

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Medicaid & the Children's Health Insurance Program

- Medicaid waivers allow the state to receive Federal Medicaid matching funds for its expenditures that normally would not be covered, even though it is no longer in compliance with certain requirements or limitations of the Federal Medicaid statute.
- Waivers allow states alternatives to delivering care from traditional Medicaid.
 - Section 1915(b) waivers—States may restrict the choice of providers that Medicaid beneficiaries would otherwise have.
 - Program waivers such as the 1915() waiver for home-and community-based services— States may receive Federal matching funds for services for which Federal matching funds are not otherwise available.
 - Demonstration waivers such as the section 1115 waivers—States may receive Federal
 matching funds for covering certain categories of individuals for which Federal matching
 funds are not otherwise available.

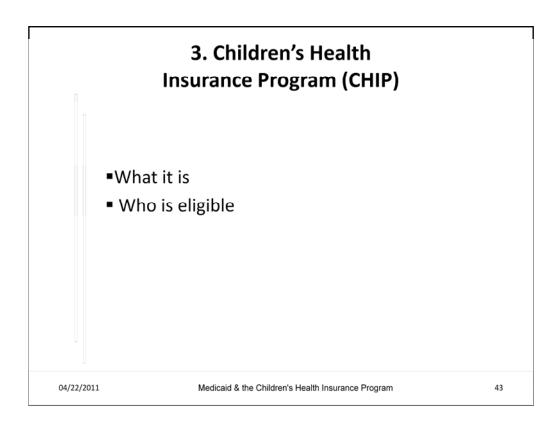
To Apply

- If you might qualify for a Medicare Savings Program
 - Review your local guidelines
 - Collect your personal documents
 - Contact local agencies for more information
 - Complete application with state Medical Assistance office

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Medicaid & the Children's Health Insurance Program

- Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses
 - First, review the income and resource (or asset) guidelines for your area.
 - If you think you may qualify, collect the personal documents the agency requires for the application process. You will need
 - Medicare card
 - Proof of identity
 - Proof of residence
 - Proof of any income, including pension checks, Social Security payments, etc.
 - Recent bank statements
 - Property deeds
 - Insurance policies
 - Financial statements for bonds or stocks
 - Proof of funeral or burial policies
- You can get more information by contacting your state Medical Assistance office, your local SHIP program, or your local Area Agency on Aging.
- Finally, complete an application with your state Medical Assistance office.



- This section explains the Children's Health Insurance Program (CHIP).
 - What it is
 - Who is eligible

Overview of CHIP

- Children's Health Insurance Program (CHIP)
- Title XXI of the Social Security Act
- Part of the Balanced Budget Act of 1997
- Covers America's uninsured children
- Joint Federal and state financing
 - Federal Medical Assistance Percentages (FMAP)
- Administered by each state
- State option to design program

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Medicaid & the Children's Health Insurance Program

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- The Children's Health Insurance Program (CHIP), previously called the State Children's Health Insurance Program (SCHIP), was created as part of the Balanced Budget Act of 1997, with strong, bi-partisan support for covering America's uninsured children. This was the largest expansion of public health insurance coverage since the creation of Medicare and Medicaid in 1965. It is under title XXI (21) of the Social Security Act.
- CHIP is jointly financed by the Federal and state governments and is administered by the states.
 - Federal Medical Assistance Percentages (FMAP) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year. The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages. "Enhanced Federal Medical Assistance Percentages" are for the Children's Health Insurance Program (CHIP) under Title XXI (21) of the Social Security Act.
- Within broad Federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Each state has the option to expand Medicaid, create a stand-alone program, or create a combination program.

More information on CHIP is available at http://www.cms.gov/CHIPRA/01 Overview.asp#TopOfPage

CHIPRA

- Children's Health Insurance Program
 Reauthorization Act of 2009
- Also known as PL 111-3
- Reauthorized CHIP effective February 4, 2009
 - "S" dropped
 - -SCHIP now known as CHIP

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Medicaid & the Children's Health Insurance Program

- CHIPRA, or the Children's Health Insurance Program Reauthorization Act, reauthorized the CHIP program effective February 4, 2009. With the CHIPRA reauthorization, along with other changes to the program, the "S" was dropped off of SCHIP and now the program is just called CHIP.
- CHIPRA is also known as Public Law (PL) 111-3.

What Has Not Changed

- Still provides health insurance for children
 - Up to age 19 and those not already insured
 - Must meet other requirements
- It is still a Federal/state partnership
- States still set own guidelines within Federal rules
- The way CHIP is funded (not an entitlement program)

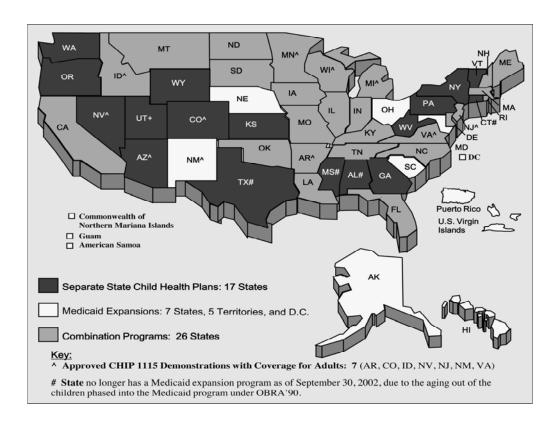
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There are some things about the CHIP program that remain unchanged by CHIPRA.

- The program gives each state authority to provide health insurance for children, up to age 19, who are not already insured (within limitations) and who meet other requirements.
- CHIP is a partnership with the states who administer their program within the Federal guidelines.
- Because each state sets its own guidelines, there is not one nationwide SCHIP/CHIP program but all must meet certain Federal parameters.
- Unlike Medicaid, CHIP has never been an entitlement program. CHIPRA does not change that status.



■ This chart shows the design of the CHIP programs chosen by each state and the U.S. Territories.

NOTE: This map is provided as a handout in the corresponding workbook (see Appendix D).

Who Is Eligible?

- Uninsured children and pregnant women
 - Family income too high for Medicaid
- CHIPRA makes it easier to obtain and access
 CHIP health care for
 - Uninsured children with higher income
 - -Uninsured low income pregnant women
 - Children born to women receiving pregnancyrelated assistance
 - · Get automatic enrollment in Medicaid or CHIP

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Medicaid & the Children's Health Insurance Program

- Uninsured children and pregnant women with family income that is too high for Medicaid may be eligible for CHIP.
- The new CHIPRA legislation makes it easier for certain groups to obtain and access CHIP health care. These include
 - Uninsured children with higher income
 - Uninsured low income pregnant women
 - Automatic enrollment in Medicaid or CHIP for children born to women receiving pregnancyrelated assistance

CHIPRA Eligibility & Enrollment Processes

- States can use public "Express Lane agencies"
 - For initial eligibility and redetermination
- Allows for auto enrollment
- State required to
 - Verify ineligibility
 - Document citizenship
 - Compute and report payment reviews

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Medicaid & the Children's Health Insurance Program

- CHIPRA allows states to use public agencies and their application and eligibility determination process for initial eligibility determination and redetermination for Medicaid and CHIP. These are called "Express Lane agencies."
- CHIPRA also allows for the option to auto enroll without a signature or application form. The child's parent or guardian must consent to enrollment.
- State is required to
 - Verify ineligibility (check the accuracy of the information provided to the Express Lane agency.)
 - Document citizenship (still required)
 - Compute and report payment reviews

Citizenship Changes

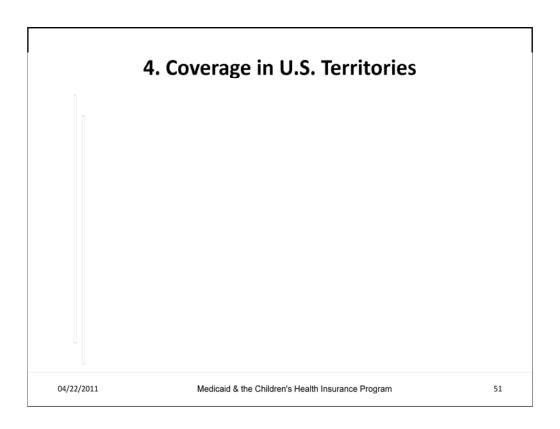
- CHIPRA gives options
 - State may lift five-year ban on covering legal immigrants
 - Citizenship documentation requirements apply
 - Tribal membership and enrollment documents satisfy requirements
- Changes retroactive to 2006

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Medicaid & the Children's Health Insurance Program

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CHIPRA gives states the option to lift the five-year ban on covering legal immigrants, applies citizenship documentation requirements to CHIP, deems Tribal Membership and enrollment documents to satisfy citizenship and identity requirements except for tribes with international borders whose members are not U.S. citizens. These changes are retroactive to 2006.



■ This section explains coverage in U.S. Territories.

Programs in U.S. Territories

- Medicaid/other programs available in U.S. territories
 - Puerto Rico
 - Virgin Islands
 - Guam
 - Northern Mariana Islands
 - American Samoa
- Programs vary
 - Contact Medical Assistance office

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Medicaid & the Children's Health Insurance Program

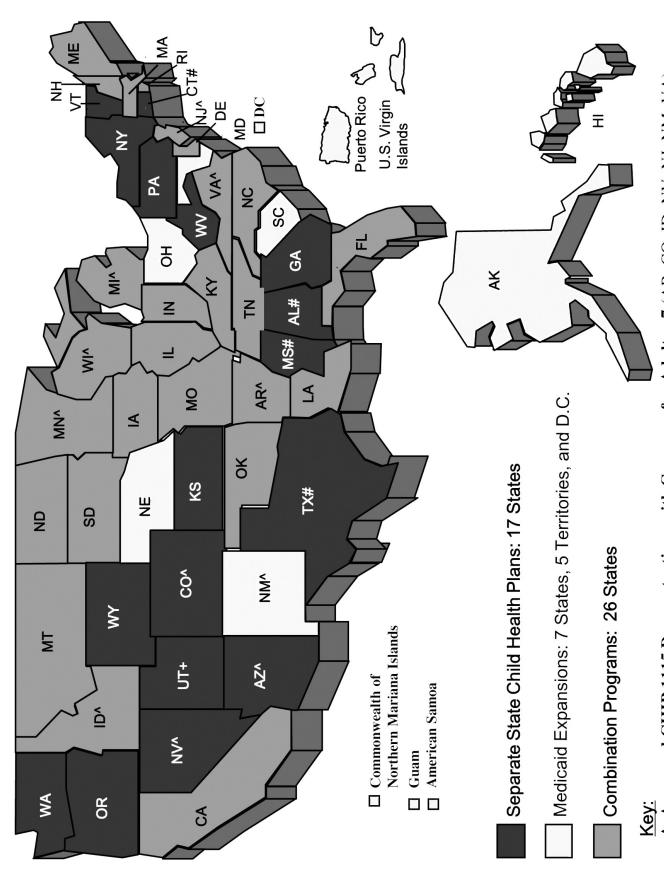
- Medicaid and other programs to help people with limited income and resources are also available for those who live in the U.S. territories
 - Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
- Programs also vary in these areas.
- Contact the Medical Assistance office in your area for more information.

Informat	Information Sources for Medicaid & CHIP	caid & CHIP
Government Resources	Industry Resources	Medicare Products
www.medicare.gov	State Health Insurance Assistance Programs (SHIPs)*	Medicare & You Handbook CMS Product No. 10050)
www.cms.gov/home/medicaid.asp www.socialsecurity.gov	State Office on Aging *For telephone numbers call CMS	Your Medicare Benefits CMS Product No. 10116
www.cms.gov/center/ombudsman	1-800-MEDICARE (1-800-633-4227) 1-877-486-2048 for TTY users	To access these products:
Centers for Medicare &		Medicare.gov
Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)		Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization.
Social Security Administration 1-800-772-1213 (TTY 1-877-486-2048)		

How are Medicare an	care and Medicaid different?
Medicare	Medicaid
National program that is consistent across the country	Statewide programs that vary among states
Administered by the Federal government	Administered by state governments within Federal rules (Federal/state narthershin)
Eligibility based on age, disability, or End–Stage Renal Disease (ESRD)	Eligibility based on need; financial and non-financial requirements
Nation's primary payer of inpatient hospital services to the elderly and people with ESRD	Nation's primary public payer of acute health, mental health, and long-term care services

Medicare Savings		Helps Pay
Program	Eligibility	Your
Qualified	Eligible for Medicare Part A	Part A and
Medicare	Income not exceeding 100% FPL	Part B
Beneficiary	Resources not exceeding the full LIS subsidy resource	premiums,
(QMB)	level	deductibles,
	– For 2010: \$6,600 individual/\$9,910 married couple living	co-insurance,
	together with no other dependents	and copays
	Effective the first of the month after QMB eligibility is	•
	determined	
	Eligibility cannot be retroactive	
Specified	Eligible for Medicare Part A	Part B
Low-income	■ Income at least 100%, but not exceeding 120% of FPL	premium
Medicare	Resources not exceeding the full LIS subsidy resource	
Beneficiary	level	
(SLMB)	– For 2010 \$6,600 individual/\$9,910 married couple living	
	together with no other dependents	
	 Eligibility begins immediately and can be retroactive up 	
	to three months	

•	Eligibility	Helps Pav Your
Individual In	dicare t 120% excee	Part B premium
	 Esource level For 2010 \$6,600 for an individual/\$9,910 married couple living together with no other dependents Eligibility begins immediately and can be retroactive up to three months 	
Qualified	 Entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity (SGA) Income not higher than 200% FPL Resources not exceeding twice maximum for SSI For 2010: \$4,000 for an individual/\$6,000 married couple living together with no other dependents Cannot be otherwise eligible for Medicaid 	Part A premium



A Approved CHIP 1115 Demonstrations with Coverage for Adults: 7 (AR, CO, ID, NV, NJ, NM, VA)

State no longer has a Medicaid expansion program as of September 30, 2002, due to the aging out of the children phased into the Medicaid program under OBRA'90.



E-mail: NMTP@cms.hhs.gov Website: cms.gov/NationalMedicareTrainingProgram

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